

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07521/90
Reg. Dist. No.

07523

1. PLACE OF DEATH a. COUNTY Howard			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N.Y. b. COUNTY Erie		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterloo		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Buffalo 69X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 1 and 175			d. STREET ADDRESS 599 N. Division St.		
3. NAME OF DECEASED (Type or print) ROLAND (ROLON) CANNON			4. DATE OF DEATH Month 7 Day 30 Year 57		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1907		9. AGE (in years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Effingham S.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Ben. Cannon.		
14. MOTHER'S MAIDEN NAME Lizzie Evans			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 229-24-2904		
16. SOCIAL SECURITY NO. 229-24-2904			17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Skull Fractures, laceration of brain 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe contusion of chest					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car traveling S.Rt. 1 made left turn in front of tractor-trailer			
20c. TIME OF INJURY Month, Day, Year 12, 20, 7-30-57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Waterloo Howard Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-30-57	
EXAMINER'S NAME (Type) Charles S. Whitaker		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8/2/1957	22c. NAME OF CEMETERY OR CREMATORY Buffalo		22d. LOCATION (City, town, or county) (State) New York	
23. FUNERAL DIRECTOR'S SIGNATURE Isaiah L. Brown & Son		ADDRESS 108 W. Montgomery St.		24a. REC'D BY REGISTRAR AUG 6 1957	
				24b. REGISTRAR'S SIGNATURE <i>E. Bird Williams</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME	JOHN J. CARROLL
AGE	45
SEX	MALE
RACE	WHITE
DATE OF BIRTH	1912-10-15
DATE OF DEATH	1957-08-06
PLACE OF BIRTH	BALTIMORE, MARYLAND
PLACE OF DEATH	BALTIMORE, MARYLAND
CAUSE OF DEATH	HEART DISEASE
MANNER OF DEATH	NATURAL
DEATH CERTIFICATE	FILED

BUREAU V. S.

AUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07524 CERTIFICATE OF DEATH

07522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Glenwood			
3. NAME OF DECEASED (Type or print) HARRY GARLAND First Middle Last				4. DATE OF DEATH Month July Day 18 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1875		9. AGE (In years last birthday) 81 yrs.		10. UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James H. Clark				14. MOTHER'S MAIDEN NAME Lavenia Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Howard W. Clark Address Glenelg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis-Nephritis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days Months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February, 1955 , to July 16, 1957 , that I last saw the deceased alive on July 16, 1957 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 7/18/57							
ACTUAL SIGNATURE [Signature] M.D. Sandy Spring, Md.				PHYSICIAN'S NAME (Type) J. W. Bird, M.D. Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/21/57		22c. NAME OF CEMETERY OR CREMATORY Oak Grove		22d. LOCATION (City, town, or county) (State) Glenwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. HIGINBOTHOM Address Ellicott City, Md.				24. RECEIVED BY REGISTRAR JUL 22 1957 24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, cause of death, and place of death. The form is partially filled out with handwritten text.

Handwritten text in the form:

- NAME: *John A. Smith*
- AGE: *45*
- SEX: *Male*
- RACE: *White*
- DATE OF DEATH: *July 22, 1957*
- PLACE OF DEATH: *Home*
- CAUSE OF DEATH: *Heart Disease*

BUREAU V. 8

JUL 22 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07525

CERTIFICATE OF DEATH

07528

Reg. Dist. No.

19 1

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 5 Wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TAYLOR MANOR HOSP		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 3001-4	
3. NAME OF DECEASED (Type or print) NORMANDA. First Middle Last		4. DATE OF DEATH Month 7 Day 5 Year 1957	
5. SEX M.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1889 9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tavern Owner Own		10b. KIND OF BUSINESS OR INDUSTRY Own	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey Clarke		14. MOTHER'S MAIDEN NAME Emma Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Anna Clarke, 1023 Wildwood Pkwy		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis, cerebral senescence 334x DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19 , 19 56 , to 7-5 , 19 57 , that I last saw the deceased alive on 7-5 , 19 57 , and that death occurred at 6:45 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving J. Taylor M.D. Taylor Manor Hospital		ADDRESS (Street, city or town, state) Ellicott City Md DATE SIGNED 7-5-57	
PHYSICIAN'S NAME (Type) IRVING J. TAYLOR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF Jul. 8/57	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke, Funeral Dir.		24a. REC'D BY REGISTRAR 7/8/57 24b. REGISTRAR'S SIGNATURE J. E. Laughery	

CERTIFICATE OF DEATH

1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 15

BUREAU V. S.

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07524

Reg. Dist. No. 215

07526

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Howard and c. LENGTH OF STAY IN 1b New Rt. 29 Montgomery Co. Line d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 mile So. Scaggsville				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Pennsylvania b. COUNTY Baltimore 72-X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Murrysville, (Rural) (Delivery #2 Baltimore XXXX XXXX (Wakesville) d. STREET ADDRESS 12 Maxwell XXX Box 72-B e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT KLINE EYLER				4. DATE OF DEATH Month Day Year July 25 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 20, 1937	
9. AGE (In years last birthday) 19 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U S Navy		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Robinson EYLER				14. MOTHER'S MAIDEN NAME Mildred Kline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (Current)		16. SOCIAL SECURITY NO. 215-34-1269		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Fractures of Skull, Haw, Rt. Leg 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Instant							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran off road and struck end of bridge					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 2 AM 7-25-57 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) 2 mile S. of Scaggsville Rt. 29 Howard Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank E Shipley M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank E. Shipley M D				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 29 Jul. 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia		22e. REC'D BY REGISTRAR DATE 7-26-57		22f. REGISTRAR'S SIGNATURE Mary E. Parrelly			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 29 1957

RECEIVED

07527

CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) ELKRIDGE 27</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 (RURAL) ELKRIDGE 27</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY ROAD</u>				d. STREET ADDRESS <u>1 MONTGOMERY ROAD</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>LOUISE</u> Last <u>HOBBS</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 22, 1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>AUGUST NICOLAI</u>				14. MOTHER'S MAIDEN NAME <u>MARY WEHLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Joseph E. Hobbs, ELKRIDGE 27, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Heart Disease recurrent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Chr Myocarditis</u> DUE TO (c) <u>Compensation</u> <u>General Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 10 hrs</u> <u>1 yr</u> <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct 2, 1956</u> to <u>July 4, 1957</u> , that I last saw the deceased alive on <u>July 4, 1957</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B B Brumblough M.D.</u>				ADDRESS (Street, city or town, state) <u>3609 main st Elkridge 27 Md</u>			
DATE SIGNED <u>7/9/57</u>							
PHYSICIAN'S NAME (Type) <u>B B Brumblough</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>				24a. REC'D BY REGISTRAR <u>J. E. Long</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Long</u>	
ADDRESS <u>Easton Sons, Catonsville 28, Md.</u>				DATE <u>JUL 9 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 9 1957

RECEIVED

07528 **CERTIFICATE OF DEATH**

Item 8 Film Q218 7-18-57 et

Reg. Dist. No. 190

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Howard	MARYLAND	STATE Maryland	COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkridge	LENGTH OF STAY (in this place) 25 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1912 St. Augustine Ave.		STREET ADDRESS (If rural give location) 1912 St. Augustine Ave.	
3. NAME OF DECEASED (Type or Print) John O. Merson		4. DATE OF DEATH (Month) (Day) (Year) July 13, 1957	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 25, 1931
9. AGE last birthday 26 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Federal Tin	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-10-2857	
17. INFORMANT & ADDRESS Mary A. Merson 1912 St. Augustine Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cardio-Vascular Decompensation		INTERVAL BETWEEN ONSET AND DEATH 1 month	
ANTECEDENT CAUSE(S) DUE TO (B) Pulmonary Emphysema		2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 4/3/53		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED White at work Not white at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 7/13/57, and that death occurred at 8:00 A.M. from the causes and on the date stated above.			
SIGNATURE Mark E. Shipley, M.D.		ADDRESS (Street, city, town, state) Savage, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 16, 1957	
NAME OF CEMETERY OR CREMATORY Meadowridge		LOCATION (City, town, or county) (State) Dorsey, Howard, Maryland	
24. REC'D BY REGISTRAR DATE 1-1-1957		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ambrose, Inc. 1328 Sulphur Sp. Rd	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Received

25

ROBERT W. B.

JUL 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07529

CERTIFICATE OF DEATH

07529

196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City Rural c. LENGTH OF STAY IN 1b Ellicott City Rural d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 39 Allview Drive				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City Rural d. STREET ADDRESS 39 Allview Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRIETTA RITZENTHALER				4. DATE OF DEATH Month July Day 5 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-14-1863	
9. AGE (In years last birthday) 93		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Norwalk Ohio	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Jacob Urban				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Richard Germann, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/6/1956 , to 7/5/1957 , that I last saw the deceased alive on 7/5/1957 , and that death occurred at 11:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Charles S. Whitaker , M.D.				PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland 7/6/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-8-57		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR 9 1957		24b. REGISTRAR'S SIGNATURE J. P. Dougherty	

RECEIVED

1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07528

07530

CERTIFICATE OF DEATH

Reg. Dist. No.

192

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Friendship				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM WELLING SMALLWOOD				4. DATE OF DEATH Month Day Year July 4 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1899	9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff		10b. KIND OF BUSINESS OR INDUSTRY Sheriff Dept.		11. BIRTHPLACE (State or foreign country) Dayton, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William W. Smallwood				14. MOTHER'S MAIDEN NAME Florence Iglehart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 212-34-3241		17. INFORMANT Mrs. Ada Smallwood		Address West Friendship, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerotic heart disease with auricular fibrillation						INTERVAL BETWEEN ONSET AND DEATH 3 mins.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from January 1, 1955, to July 4, 1957 , that I last saw the deceased alive on June 21, 1957 , and that death occurred at 6:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles S. Whitaker, M.D. M.D.							
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland 7/4/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Highland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham				ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR DATE JUL 8 1957	
				24b. REGISTRAR'S SIGNATURE Allice Kelly			

BUREAU V. S.

JUL 8 1905

RECEIVED

07531

CERTIFICATE OF DEATH

07529
194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rt # 32</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MARIE</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 1931</u>
9. AGE (In years last birthday) <u>25</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY Jenson</u>		14. MOTHER'S MAIDEN NAME <u>Roberta Bromgoolie</u>	
15. WAS DECEASED EVER IN U. S. A. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Henry Jenson - Simpsonville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA BILATERAL</u> <u>4 TUBA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>VIRAL GASTRITIS, SEVERE</u> DUE TO (b) <u>1 wk.</u> DUE TO (c) <u>1 wk.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ANXIETY NEUROSIS (R/C CROWNSVILLE STATE HOSP.)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 1956</u> , to <u>JULY 1957</u> , that I last saw the deceased alive on <u>JULY 26 1957</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald E. Fisher</u> M.D.		ADDRESS (Street, city or town, state) <u>Edgewood City Md.</u> DATE SIGNED <u>7-26-57</u>	
PHYSICIAN'S NAME (Type) <u>DONALD E. FISHER M.D.</u>			
22a. BURIAL, CREMATION, <u>Burial</u> (Specify)	22b. DATE THEREOF <u>7/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Chapel.</u>	22d. LOCATION (City, town, or county) (State) <u>Highland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Zuerden</u>		ADDRESS <u>Rockville, Md.</u>	24a. REC'D BY REGISTRAR <u>Marie Whitaker</u> 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 1 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY A A	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN TB 210 Bertram Circle, Glenburnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 144		d. STREET ADDRESS 02X22	
3. NAME OF DECEASED (Type or print) First ERNEST Middle EARL Last SWANSON		4. DATE OF DEATH Month July Day 1 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1902
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Swanson		14. MOTHER'S MAIDEN NAME Jennie A. Bolyard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-10-1535	
17. INFORMANT James Swanson, Glenburnie, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholism 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin		DATE SIGNED 7/2/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-3-57	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd	22d. LOCATION (City, town, or county) (State) Ellicott City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR JUL 5 1957	
		24b. REGISTRAR'S SIGNATURE J. E. Laughery	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATEMENT OF DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 5 1957

RECEIVED

Dr. W. J. Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07531

07533

Reg. Dist. No. 190

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City (Clarksville)		c. LENGTH OF STAY IN 1b X/ Ellicott City (Clarksville)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Haylases Farm - Sheppard Lane		d. STREET ADDRESS Haylases Farm - Sheppard Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CAROLYN Middle R. Last THOMAS		4. DATE OF DEATH Month July Day 29 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY self employed	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Ripperger		14. MOTHER'S MAIDEN NAME Mary E. -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Excluded		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. Harry G. Thomas, Jr. - Sheppard Lane, Clarks-		Address ville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Woodlawn, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		DATE SIGNED 7/29/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/1/57	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baltimore		24a. REC'D BY REGISTRAR Jul 31 1957	
ADDRESS Baltimore		24b. REGISTRAR'S SIGNATURE St. Loughery	

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU OF HEALTH

JUL 31 1957

RECEIVED

Paul F. Rine